



*State of California*

## **OFFICE OF THE INSPECTOR GENERAL**

**MATTHEW L. CATE, INSPECTOR GENERAL**

**FOR IMMEDIATE RELEASE**

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**Proper security at the California Institution for Men may have prevented the death of  
Correctional Officer Manuel A. Gonzalez, Jr.**

The Office of the Inspector General — the watchdog for California’s correctional system — today released the results of a seven-week special review into the circumstances surrounding the January 10<sup>th</sup> stabbing death of Correctional Officer Manuel A. Gonzalez, Jr. at the California Institution for Men.

Officer Gonzalez’s alleged assailant, Jon Christopher Blaylock, a 35-year-old inmate at the California Institution for Men who was already serving a 75-year term for the 2002 attempted murder of a police officer, was charged by the San Bernardino County District Attorney’s Office with murder of the officer.

Inspector General Matthew L. Cate reported that a host of security problems at the prison led up to the attack. In the housing unit where the stabbing occurred, correctional officers — including Officer Gonzalez — routinely ignored security protocols and disregarded extra security measures put into place after a December 19<sup>th</sup> riot between Blacks and Hispanic inmates at the housing unit.

Just before he was attacked, Officer Gonzalez violated protocols by allowing Blaylock to be released from his cell because he believed Blaylock was a “shot-caller” who could help calm other Black inmates and return the unit to regular programming. After doing so, Officer Gonzalez entered the tier alone to speak with Blaylock, and the attack occurred.

“Responsibility for the attack ultimately rests with the assailant,” said Cate, “but it is vital to the future safety of all officers that the Department of Corrections address the factors that contributed to this tragedy.”

Cate noted that this was a “perfect storm scenario,” in which correctional officers, in their zeal to accomplish a difficult job in tough circumstances, failed to follow security requirements. In addition, supervisors and managers failed to hold officers accountable for adhering to required protocols.

The Inspector General also said that inmates at the facility have had easy access to weapons-making materials because the housing unit is in serious disrepair and control over tools and other equipment is lax. Correctional officers responsible for conducting regular cell searches had not been doing so. After the stabbing, a thorough search of the housing unit yielded approximately 35 inmate-manufactured weapons.

The Inspector General’s report cites numerous other problems at the prison that may have contributed to the tragedy. In particular, the Inspector General found that Blaylock was being kept in a general population cell even though he had been previously classified as a maximum security inmate with a long history of in-prison violence and should have been put in an administrative segregation unit pending a placement review by a classification committee.

The review also revealed that the California Institution for Men had received 362 protective vests for its officers in September 2004, and had been storing them in a warehouse until it had updated its protocols and obtained enough vests for all officers who had been designated to receive them. Officer Gonzalez’s vest was in the warehouse at the time of the stabbing.

When the stabbing occurred, the Inspector General said the prison medical clinic where Officer Gonzalez was taken was poorly equipped and ill-prepared to handle the emergency, however his wounds were so severe that the deficiencies may not have contributed to his death.

“No one can say whether any of these problems cost Officer Gonzalez his life,” said Cate, “but certainly they need to be remedied before any other officer faces similar peril.”

The full text of the Inspector General’s public report on the review can be viewed and downloaded from the Office of the Inspector General’s web site at <http://www.oig.ca.gov/> . To view the report on

the website, click on the report title, “Special Review Into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men,” on the home page or on the link titled “Reports.”

The Office of the Inspector General is an independent state agency responsible for oversight of the California correctional system, including the Department of Corrections and the California Youth Authority. The office carries out its mission by auditing and investigating correctional organizations under the Youth and Adult Correctional Agency to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses by staff, supervisors, and management. The special review was conducted under the authority provided to the Inspector General by Penal Code section 6126.

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